WAYS AND MEANS

Medicare Part B Improvement Act (H.R. 3178)

Section-by-Section

Section 1: Short Title – The *Medicare Part B Improvement Act of 2017.*

Title I – Improvements in Provision of Home Infusion Therapy

Section 101: Home Infusion Therapy Services Temporary Transitional Payment (H.R. 3163, Tiberi, Pascrell)
The 21st Century Cures Act (Cures) (1) changed the way Medicare pays for home infusion services beginning in 2017, and (2) created a new Medicare benefit for home infusion education and services provided by clinicians delivering infusion to patients in their homes beginning in 2021. Since the payment change began in 2017 and the new benefit begins in 2021, beneficiaries could experience home infusion access issues during the four years between the change in payment policy and the new home infusion nursing benefit. This section would address this gap by creating a temporary transition service and education Medicare payment for home infusion beginning in 2019.

Section 102: Extension of the Medicare Patient IVIG Access Demonstration Project (H.R. 3172, Brady, Matsui)
This section would extend the intravenous immunoglobulin (IVIG) demonstration policy originally enacted in 2012 (sponsored by Chairman Brady and Reps. Matsui and Kind) for an additional three years, until 2020. The demonstration would evaluate the benefits of providing payment for items and services needed for the in-home administration of IVIG for the treatment of primary immune deficiency diseases.

Section 103: Orthotist's and Prosthetist's Clinical Notes as Part of the Patient's Medical Record (H.R. 3171, Bishop, Thompson)
Medicare pays for orthotics and prosthetics for beneficiaries who medically need those items. Medicare's claims review process to prevent fraud and abuse in certain cases has led to payment denials for medically necessary orthotics or prosthetics as a result of insufficient

evidence and incomplete medical record notes to document medical necessity. Currently, some suppliers are experiencing a delay in payment for prosthetics already paid for and supplied to Medicare beneficiaries. This section would allow additional information provided by prosthetists and orthotists, who evaluate and fit the beneficiary for the orthotics and prosthetics, to be considered by Medicare to support documentation of medical necessity for orthotics and prosthetics.

Title II – Improvements in Dialysis Services

Section 201: Independent Accreditation for Dialysis Facilities and Assurance of High Quality Surveys (H.R. 3166, Jenkins, Lewis)
Facilities that provide care for Medicare beneficiaries must satisfactorily complete both a state survey and certification process as well as the Medicare accreditation process in order to participate in the Medicare program. Some providers may use an outside agency to survey and accredit their facility for Medicare participation, however this avenue is not available to dialysis facilities. This may result in access issues for end-stage renal disease (ESRD) patients, in areas where certification and accreditation does not keep pace with companies' ability to construct facilities. This section would allow dialysis providers to seek outside accreditation, from organizations approved by Medicare, in order to be able to bill Medicare for ESRD services.

Section 202: Expanding Access to Home Dialysis Therapy (H.R. 3164, Black, DelBene, Thompson, Meehan)
Medicare does not reimburse for telehealth services for beneficiaries in their homes. For ESRD patients who choose to undergo dialysis treatment at home, telehealth could allow for additional necessary monitoring without additional trips to a providers' office. This section would allow ESRD providers to utilize telehealth for home dialysis patient monitoring.

Title III – Improvements in the Application of Stark Rules

Section 301: Modernizing the Application of the Stark Rule under Medicare (H.R. 3173, Marchant, Kind)
The "Stark" physician self-referral laws are meant to prevent financial interests from interfering with clinical decisions. The Stark laws prohibit physicians from referring Medicare beneficiaries to facilities in which they (or a close family member) have a financial stake and by prohibiting that facility for billing for Medicare services performed as a result of such a referral. Violations of Stark Law can range from unknowing to willful. The Centers for Medicare & Medicaid Services (CMS) recently changed Stark law regulations relating to when leases were in violation of the Stark laws and when signatures were required to document the terms of legal arrangements. This section codifies the changes CMS made.

Section 302: Deposit of Savings into Medicare Improvement Fund
This section would reduce the amount of funding in the Medicare Improvement Fund (MIF) available to the Department of Health and Human Services to offset the policies contained in the legislation.